THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.2212a Health insurance policy; description of terms, conditions, and information; written request; style, arrangement and appearance of policy; "board certified" defined.

Sec. 2212a. (1) An insurer that delivers, issues for delivery, or renews in this state a policy of health insurance shall provide a written form in plain English to insureds upon enrollment that describes the terms and conditions of the insurer's policies. The form must provide a clear, complete, and accurate description of all of the following, as applicable:

(a) The service area.

(b) Covered benefits, including prescription drug coverage, with specifications regarding requirements for the use of generic drugs.

(c) Emergency health coverages and benefits.

(d) Out-of-area coverages and benefits.

(e) An explanation of the insured's financial responsibility for copayments, deductibles, and any other out-of-pocket expenses.

(f) Provision for continuity of treatment if a provider's participation terminates during the course of an insured person's treatment by the provider.

(g) The telephone number to call to receive information concerning grievance procedures.

(h) How the covered benefits apply in the evaluation and treatment of pain.

(i) A summary listing of the information available under subsection (2).

(2) An insurer shall provide upon request to insureds covered under a policy issued under section 3405 a clear, complete, and accurate description of any of the following information that has been requested:

(a) The current provider network in the service area, including names and locations of affiliated or participating providers by specialty or type of practice, a statement of limitations of accessibility and referrals to specialists, and a disclosure of which providers will not accept new subscribers.

(b) The professional credentials of affiliated or participating providers, including, but not limited to, affiliated or participating providers who are board certified in the specialty of pain medicine and the evaluation and treatment of pain and have reported that certification to the insurer, including all of the following:

(*i*) Relevant professional degrees.

(*ii*) Date of certification by the applicable nationally recognized boards and other professional bodies.

(*iii*) The names of licensed facilities on the provider panel where the provider currently has privileges for the treatment, illness, or procedure that is the subject of the request.

(c) The licensing verification telephone number for the department of licensing and regulatory affairs that can be accessed for information as to whether any disciplinary actions or open formal complaints have been taken or filed against a health care provider in the immediately preceding 3 years.

(d) Any prior authorization requirements and any limitations, restrictions, or exclusions, including, but not limited to, drug formulary limitations and restrictions by category of service, benefit, and provider, and, if applicable, by specific service, benefit, or type of drug.

(e) The financial relationships between the insurer and any closed provider panel, including all of the following as applicable:

(*i*) Whether a fee-for-service arrangement exists, under which the provider is paid a specified amount for each covered service rendered to the participant.

(*ii*) Whether a capitation arrangement exists, under which a fixed amount is paid to the provider for all covered services that are or may be rendered to each covered individual or family.

(*iii*) Whether payments to providers are made based on standards relating to cost, quality, or patient satisfaction.

(f) A telephone number and address to obtain from the insurer additional information concerning the items described in subdivisions (a) to (e).

(3) Upon request, any of the information provided under subsection (2) must be provided in writing. An insurer may require that a request under subsection (2) be submitted in writing.

(4) A health insurer shall not deliver or issue for delivery a policy of insurance to any person in this state unless all of the following requirements are met:

(a) The style, arrangement, and overall appearance of the policy do not give undue prominence to any portion of the text. Every printed portion of the text of the policy and of any endorsements or attached papers must be plainly printed in light-faced type of a style in general use, the size of which must be uniform and not less than 10-point with a lowercase unspaced alphabet length, not less than 120-point in length of line. As

used in this subdivision, "text" includes all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions.

(b) Except as otherwise provided in this subdivision or except as provided in sections 3406 to 3452, exceptions and reductions of indemnity are set forth in the policy and are printed, at the insurer's option, with the benefit provision to which they apply or under an appropriate caption such as **"EXCEPTIONS"** or **"EXCEPTIONS AND REDUCTIONS"**. If an exception or reduction of indemnity specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the benefit provision to which it applies.

(c) Each form, including riders and endorsements, are identified by a form number in the lower left-hand corner of the first page of the form.

(d) The policy contains no provision that purports to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy. This subdivision does not apply to the incorporation of or reference to a statement of rates, classification of risks, or short-rate table filed with the director.

(5) As used in this section, "board certified" means certified to practice in a particular medical or other health professional specialty by the American Board of Medical Specialties, the American Osteopathic Association Bureau of Osteopathic Specialists, or another appropriate national health professional organization.

History: Add. 1996, Act 517, Eff. Oct. 1, 1997;—Am. 1998, Act 424, Eff. Apr. 1, 1999;—Am. 2001, Act 235, Imd. Eff. Jan. 3, 2002;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: Enacting section 1 of Act 235 of 2001 provides:

"Enacting section 1. The 2001 amendatory act that added section 2212a(4) to the insurance code of 1956, 1956 PA 218, MCL 500.2212a, shall not be construed as creating a new mandated benefit for any coverages issued under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302."

Popular name: Act 218